Medicare Prescription Drug, Improvement, and Modernization Act of 2003

PACE PROVISIONS

Section 236

There are several provisions of the new law which have an impact on PACE Programs.

Drug Discount Card and Part D Drug Benefit Provisions

Background

- Programs of All-Inclusive Care for the Elderly (PACE) provide to frail elderly individuals who are eligible for Medicare and/or Medicaid a comprehensive package of community-based services covered by both programs under a capitated payment system. PACE is a permanent part of the Medicare program and is an optional service for state Medicaid plans. PACE programs only operate in states that have chosen this option.

- Most PACE participants are eligible for both Medicare and Medicaid; about 5% are eligible only for Medicare. Once enrolled in PACE, all participants receive the full Medicare and Medicaid benefit packages, regardless of their original Medicare or Medicaid status.

New Provisions in the Act

- All state Medicaid programs currently elect to provide the optional prescription drug benefit and all PACE participants receive Medicaid-covered prescription drugs; therefore, they are not eligible for the discount card.

- For Part D, the definition of full-benefit dual eligible individual in section 1935(c)(6), it is clear that all PACE participants originally eligible for both Medicare and Medicaid would qualify as full benefit dual eligibles. Full benefit dual eligibles qualify automatically for low-income subsidies of Part D premiums and cost-sharing.

- It is not entirely clear whether those originally eligible only for Medicare would qualify as full-benefit dual eligibles and thus automatically qualify for low-income subsidies. Medicare-only PACE enrollees do receive full Medicaid benefits, although they pay the Medicaid portion of the capitation rate to the PACE program as a premium. They may be able to qualify for low-income subsidies based on their incomes and assets if they do not qualify as full benefit dual eligibles.

- PACE programs may only provide Part D drug coverage to participants enrolled with them for the full PACE program. If they do, they will be treated in a similar manner to MA-PD local plans and the Secretary may deem them to be such MA-PD local plans.

Section 236 - Payment by PACE Providers for Medicare and Medicaid Services Furnished by Non-Contract Providers

Background

- PACE programs enter into contracts (specifying payments and other conditions) with various types of providers, physicians, and other entities to furnish care to their participants. Sometimes, a PACE participant needs to use a non-contract provider, physician, or other entity, which can then charge the PACE program high amounts for that care. Such high charges make it more difficult for a PACE program to operate within its capitation payments.

New Provisions in the Act

- The law extends Medicare Advantage limits on balance billing to cover PACE programs. Medicare-participating providers, physicians, and other entities must accept these limits when they furnish Medicare-covered services to a participant of a PACE program with which they do not have a contract or other agreement establishing payment amounts.

- Providers participating under a State Medicaid program must accept payments of no more than those they would receive under the State plan when they furnish services covered under Medicaid but not under Medicare to a participant of a PACE program with which they do not have a contract or other agreement establishing payment amounts.

- These provisions are effective for services furnished on or after January 1, 2004.